

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011931

STATE FILE NUMBER

FILED APR 14 1959

Registration District No. 324

Primary Registration District No. 3072

Registrar's No. 64

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Marshall</b>		c. CITY OR TOWN <b>Marshall</b> <sup>0912</sup> / <sub>6</sub>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Fitzgibbon Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>222 N. Jefferson</b>	
Length of stay in lb <b>9 years</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>Henry</b> Last <b>Haynie</b>			4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1868</b>	9. AGE (In years last birthday) <b>90</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (City and state or country) <b>Saline County, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Edwin Moore Haynie</b>			
13b. MOTHER'S MAIDEN NAME <b>Sarah Grayson</b>		14. NAME OF HUSBAND OR WIFE <b>Ione Davis Haynie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Ione Haynie Marshall, Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vas. Accident</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Dehydration &amp; acidosis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days.</b> <b>4 days.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>332x</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>11:20 PM</b> Month, Day, Year <b>Apr. 9</b> a.m. <b>11:20 PM</b> p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <b>Marshall Mo</b>	COUNTY <b>Saline</b> STATE <b>Missouri</b>
21. I attended the deceased from <b>Apr. 9</b> to <b>Apr. 10</b> and last saw her alive on <b>Apr. 10</b> . Death occurred at <b>11:20 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <b>Dr. Campbell</b> (Degree or title)	22b. ADDRESS <b>Marshall Mo</b>	22c. DATE SIGNED <b>4-11-59</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-12-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Miami Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Miami, Missouri</b>
24. FUNERAL DIRECTOR <b>Campbell-Lewis</b>		25. DATE RECD. BY LOCAL REG. <b>4-11-59</b>	26. REGISTRAR'S SIGNATURE <b>Carl H. Read</b>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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1-57

Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
by me, or by ....., Student Embalmer No. ....  
working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed.....*RW Campbell Jr*

Licensed Embalmer No..*3468*.....

P. O. Address..*Marshall*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.